PUBLIC REPORT OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
NAIC # 62308 CDI # 0409-3

AS OF MARCH 31, 2003

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

TABLE OF CONTENTS

DEPARTMENT OF INSURANCE
Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

December 22, 2003

The Honorable John Garamendi
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims practices and procedures in California of:

Connecticut General Life Insurance Company

NAIC #62308

Hereinafter referred to as the Company.

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

SCOPE OF THE EXAMINATION

The examination covered the claims handling practices of the aforementioned Company during the period April 1, 2002 through March 31, 2003. The examination was made to discover, in general, if these and other operating procedures of the Company conform with the contractual obligations in the policy forms, to provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR), the California Vehicle Code (CVC) and case law. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. Any alleged violations of other relevant laws which may result from this examination will be included in a separate report which will remain confidential subject to the provisions of CIC Section 735.5.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of claims files and related records.

3. A review of consumer complaints received by the California Department of Insurance (CDI) in the most recent year prior to the start of the examination.

The examination was conducted primarily at the Company's offices located in Visalia, California and Pittsburg, Pennsylvania.

The report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains only a summary of pertinent information about the lines of business examined and details of the non-compliant or problematic activities or results that were discovered during the course of the examination along with the insurer's proposals for correcting the deficiencies. When a violation is discovered that results in an underpayment to the claimant, the insurer corrects the underpayment and the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered, however, and failure to identify, comment on or criticize activities does not constitute acceptance of such activities.

Any alleged violations identified in this report and any criticisms of practices have not undergone a formal administrative or judicial process.

CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

The examiners reviewed files drawn from the category of Closed Claims for the period April 1, 2002 through March 31, 2003, commonly referred to as the "review period". The examiners reviewed 344 Connecticut General Life Insurance claims files. The examiners cited 14 claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report. Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

Connecticut General Life Insurance Company			
CATEGORY	**CLAIMS FOR REVIEW PERIOD**	**REVIEWED**	**CITATIONS**
Term Life	748	39	8
DB Annuities	462	59	0
Group Premium Waiver	104	41	1
Group Health	1,693,461	68	5
Group Dental	769,174	68	0
Statutory Disability	198	51	0
Fully Insured Short Term Disability	6	6	0
Fully Insured Long Term Disability	50	12	0
TOTALS	2,464,203	344	14

TABLE OF TOTAL CITATIONS		
Citation	**Description**	**Connecticut General Life Insurance Company**
CCR §2695.5(e)(1)	The Company failed to acknowledge notice of claim within 15 calendar days.	7
CCR §2695.3(a)	The Company's claim file failed to contain all documents, notes, and work papers that pertain to the claim.	4
CCR §2695.7(d)	The Company persisted in seeking information not reasonably required for or material to the resolution of a claim dispute.	1
CCR §2695.7(b)(3)	The Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	1
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	1
Total Citations		14

SUMMARY OF CRITICISMS, INSURER COMPLIANCE ACTIONS AND TOTAL RECOVERIES

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. Regardless of the remedial actions taken or proposed by the Company, it is the Company's obligation to ensure that compliance is achieved. There were no recoveries discovered within the scope of this report.

1. The Company failed to acknowledge notice of claim within 15 calendar days. In seven instances, the Company failed to acknowledge notice of claim within 15 calendar days. The Department alleges these acts are in violation of CCR §2695.5(e)(1).

Summary of Company Response: The Company acknowledged the errors and states "The Company agrees, therefore, that the acknowledgement was not made in a timely manner, and will take steps to improve this process in the future."

2. The Company failed to properly document claim files. In four instances, the Company's files failed to contain all documents, notes and work papers. The Department alleges these acts are in violation of CCR §2695.3(a).

Summary of Company Response: The Company acknowledged that files are not maintained for pharmacy claims denied at the point of sale. As a result of this examination the Company states "The Company will take steps, however, to better document denied pharmacy claims."

3. The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In one instance, the Company failed to effectuate prompt, fair and equitable settlement of a claim in which liability had become reasonably clear. The Department alleges this act is in violation of CIC §790.03 (h)(5).

Summary of Company Response: The Company agrees the required document could have been requested sooner. As a result of this examination the Company will re-emphasize the importance of proper claim handling procedures to all claim handling personnel.

4. The Companies failed to comply with the Fair Claims Regulations Practices. In one instance each, the company failed to comply with the following Fair Claims Regulations Practices: CCR §2695.7(b)(3) and CCR §2695.7(d).

Summary of Company Response: The Company acknowledged that their RNC 0719 remark "code does not prompt the system to generate the DOI message on the EOB." As a result of this examination the Company agrees the "remark code should prompt the system to generate the DOI message on EOB's for partially denied claims and the Company will audit all claim remark codes accordingly." With regards to the seeking information not required (daily activity questionnaire on a quadriplegic) the Company, at the request of the insured and while

not admitting an error, stated “Given the nature of the claimant’s diagnosis, the Company determined it was reasonable to conclude that his impairment could impede his ability to complete the Disability Questionnaire independently, and the Company granted his request.”